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North Carolina
Department of Health and Human Services
Division of Medical Assistance
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May 7,2001

Michael Fiore, Director
Center for Medicaid and State Operations
Family and Children's Health Programs Group
Division of Integrated Health Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Fiore:

Enclosed please find our response to your comments and questions related to North Carolina's 1115 demonstration waiver proposal to provide family planning services.

If you have questions or need additional information, please contact Clarence Ervin, Chief of Practitioner and Clinical Services at 919-957-4020.

Sincerely;

/s/

Paul R. Pdrruzzi, Director

Enclosures

Cc: Donna Cross, HCFA Region IV, Atlanta

Question 1—Overall, more detail is needed in the proposal. As 1115 waivers are to be innovative, it is important that you specify what is innovative in this project and is not already being tested in other 1115 family planning waivers. A detailed discussion is needed of what is being provided to women and men through this project that they don't already receive through the current infrastructure.

There are two major innovations proposed in North Carolina's 1115 family planning waiver proposal—innovations which we believe will improve family planning services throughout our state in both the public and private sectors.

The first innovation will be a major emphasis on ***tailoring family planning services*** to each client based on the client's risk of unintended pregnancy. This innovation is based on the premise that tailoring family planning services (including recommended contraceptive method as well as the frequency and intensity of follow up) will result in improved patient retention and reduced rates of unintended pregnancies. (Research shows that reducing unintended pregnancies and lengthening interconceptional intervals will also reduce the risk of giving birth to a low-birthweight infant; however, the short period of time available for testing this innovation does not allow for assessing this impact.)

Once the waiver is approved, the Division of Public Health will initiate a pilot project to evaluate the tailoring innovation in ten local health departments—five of which will serve as control and five as experimental counties. The attached questionnaire (Attachment Q1-a) was developed by faculty at the UNC Sheps Center for Health Services Research. This questionnaire (with some modifications) will be administered by health care providers (physicians, nurses or nurse practitioners) in all ten of the local health departments participating in the pilot. The assessment will be completed during a client's first family planning visit (or—with continuing patients—during the first annual visit following implementation of the waiver) in order to determine each client's risk of unintended pregnancy. The innovation will be evaluated through a case/control methodology. In one county in each pair, high-risk clients will receive the standard family planning services (see multiple attachments Q1-b which detail services offered in standard family planning visits by method type) as well as the intervention described below. In the control counties, clients' risk will be assessed, but the clients will receive the standard set of services without the high-risk intervention. (Attachment Q1-c is a project timeline for the tailored intervention.)

During family planning visits each client will be given information on all contraceptive methods and will select the method of choice; however, the information from the risk assessment will assist the health care provider in counseling the client on appropriate choices of methods. Based on the results of the risk assessment and the choice of method, the provider (in both the intervention and control counties) will determine and indicate in the record whether the client is at high risk for unintended pregnancy. In all ten counties, providers will communicate the appropriate "tailored messages" during the visit to all high-risk clients. In the intervention counties, the provider will also indicate on the record the need for follow-up interventions to support the client's successful use of

contraception including specific "messages" that need to be communicated and reinforced during each "call out'' (telephone calls to be made to the client between clinic visits). (Risk assessments will be administered annually throughout the waiver period to assure that information is current.) All of the clients in the five intervention counties determined to be at high-risk for unintended pregnancy will receive at least three calls during each year. These calls will be "scripted" to include the following:

1. A lead-in to establish rapport
2. Some questions to explore current method use/experience/problems/current attitude about becoming pregnant
3. Questions about side-effects
4. The "message(s)" as appropriate tailored to the individual's risk assessment and the additional information now available as the result of the telephone conversation
5. Reminders of appointments and reinforcement of the need to keep all appointments as well as reminders of the benefits of the method
6. Referrals if appropriate

Both during the clinical visits in the intervention counties and during each "call-out," clients will be questioned as to the preferred time and location for their next "call-out.''

The telephone follow-up for high-risk patients in the five intervention counties will be handled by nurses with appropriate training and experience in family planning. During the first two years of the waiver's implementation, one or more nurses will be recruited to handle all of the "calls-out" to the high-risk clients for all five of the pilot counties. The contracted nurses will receive appropriate training, and staff at the five health departments will provide the contractors with copies of the assessment tools and specific instructions based on the assessments and other information which may be appropriate. These calls will typically be made from the contracted nurses' homes during non-traditional clinic hours (or at other times to address the preferences of the clients) in order to assure that working women will be able to receive the calls. Careful monitoring of the "calls-out" will be conducted by DPH staff to assure that the contractor is making sufficient follow-up calls to reach the clients on a timely basis and that the appropriate messages are being conveyed.

The five intervention counties will be selected from different regions of the state, and each will be matched to a control county of similar size with similar racial/ethnic mixes, and similar rates of short birth intervals and poverty. This will allow for an evaluation during the third year of the waiver to determine the effect the tailored interventions have on clients at high risk. Rates of unintended pregnancy and of short pregnancy intervals during the period of the intervention will be compared to determine the effectiveness of the intervention. (Note that in order to determine that unintended pregnancies have occurred, clients must be asked both at their clinical visit and at each "call-out'' whether they wish to become pregnant.)

Based on the outcome of the evaluation of the tailoring innovation in the third year of the waiver, modifications may be needed in the tool or other components of the intervention. However, assuming that there is significant improvement in the rates of unintendedness among the intervention counties, the innovation will be expanded throughout the state. With this expansion, health department staff in all 100 counties will receive training and will be required to add the high-risk intervention to their family planning programs. During the third year there will also be extensive marketing of the intervention to the private sector. Private sector physicians and nursing staff will be offered training in the use of the tool and the utilization of the "calls out" component of the intervention. Financial support for "calls out"—both during the pilot phase of the innovation and the statewide implementation—will be underwritten by Medicaid FFP or billed as part of the family planning visit.

Statewide implementation of the innovation will be supported by a more structured and centralized approach to "calls out." The Division of Public Health is considering adding this function to the North Carolina Family Health Resource Line. This large, multi-purpose call center serves a number of programs closely related to family planning including: North Carolina Health Choice and Health Check, First Step, Smart Start, and the American Social Health Association (dealing with sexually transmitted diseases and HIV). The family planning program hopes to build on this public health-related infrastructure and thus to enhance integrated recruitment and referrals with related programs.

Integrating the family planning "calls out" service with a statewide call center would also offer more service for patients who might want to call a health care provider or counselor after-hours concerning specific contraceptive or HIV/STI issues. While the Family Health Resource Line is not a "24-7" line for all public health programs, it does extend the capacity for "calls-in" by clients beyond the hours health departments and most physicians' offices are open, thus offering some additional support and information to high-risk clients who may also be high-risk for HIV/STI as well as for unintended pregnancies.

The second innovation the North Carolina waiver proposal will test is the hypothesis that ***family-centered recruitment, outreach, and health education*** will result in better utilization of preventive services. Prior experience in North Carolina has shown that the introduction of new eligibility for a preventive health program has not always led to significant enrollment. For example, the state's EPSDT program was underenrolled and underutilized for several years. We suspect that the failure of parents to take their eligible children to providers for these services was due to the target population's unfamiliarity with—and in some cases distrust of—the health care system. While children were being offered significant improvements in their own coverage, the parents whose initiative was essential in getting children into care were often themselves totally disenfranchised and unfamiliar with the benefits of preventive care. It is our contention that improving the health of our most needy citizens is more likely to take place when, to the degree possible, the family is seen and treated as a whole. This innovation—unlike the first—will ***be initiated statewide as early as possible following waiver approval.***

(Attachment Q 1-d includes a timeline indicating the various recruitment strategies that will be emphasized during six-month intervals in order to accomplish statewide recruitment goals along with a timeline for the tailoring innovation.)

This innovation is based on our belief that the quickest and most cost-effective way to recruit adults into the family planning program under the 1115 waiver will be to build upon the enrollments ***in*** Health Check and Health Choice. In recent years a very aggressive marketing and recruitment campaign in North Carolina has resulted in high levels of participation in Medicaid for Pregnant Women (MPW), Health Check and Health Choice. We propose to utilize the ***infrastructure*** developed to support these programs — working first to recruit the parents (both mothers and fathers) of the children already enrolled in these programs and also the young adults as they "graduate" from these programs at age 18. In many cases, all members of the family may be seen for preventive and primary care at one site resulting in greater satisfaction and increased willingness to enroll in a preventive health program. A simplified application process will be developed and, wherever feasible, whole families will be encouraged to establish eligibility for multiple programs simultaneously. Also, families already involved with these child health programs will receive information with AINS (Automated Information and Notification System) paid claims notices that the parents of covered children may be eligible for family planning services.

A streamlined approach will be used with the Medicaid ***for*** Pregnant Women program. Women will be reminded at their prenatal visits and again during the 60 days postpartum period that they will be eligible for family planning services at the same time their MPW coverage ends. The state's AINS systems will be used to notify MPW women (as they receive information about paid claims) that they and possibly their male partners are now eligible for family planning. North Carolina's WIC program also presents an important opportunity for recruiting WIC participants into family planning. Because our family planning program is an integral part of the Women's and Children's Health Section (which houses the program management for WIC, Child Health, and Maternal Health), family planning is in an excellent position to "tap into" the families being served by these programs in order to recruit newly eligible adults into family planning.

The recruitment of men into family planning has historically been much more difficult than the recruitment of women. However, North Carolina's family planning program has conducted focus groups with adult males across the state to collect ideas about how males might be motivated to participate in family planning. We believe that the following strategies will be successful:

(1) Women who participate in family planning will be reminded that with the waiver men as well as women are eligible and that they should encourage their partners to come to family planning clinics or access services in the private sector.
(2) Recruitment materials and personal contacts will stress the availability of Medicaid coverage for condoms and vasectomies.

(3) Promotional materials will be distributed at gyms and worksites (as allowed) as well as other sites frequented by males.
(4) Health departments and private providers will receive information gathered through the focus groups concerning recruitment of males and how to make clinic sites more "male friendly."
(5) Both public and private providers will be encouraged to talk to males about family planning when they visit their doctor or a health department for other services such as physicals or immunizations.
(6) Messages on posters and other media which focus on STI and HIV will also include the information about male eligibility for family planning.

For a number of years, North Carolina has worked with Guilford County to market vasectomies and to assist low-income men in accessing this procedure. In recent years, the demand for subsidized vasectomies has grown tremendously. As many as 400 vasectomies have been done in a single year with year-end program funds. Even in that year, numerous requests for vasectomies could not be addressed due to lack of funds.

North Carolina Medicaid's **AINS** (Automated Information and Notification System) will be utilized to reinforce recruitment/retention strategies by generating follow-up mailings as appointment reminders and notices of missed appointments. Recruitment activities will include a number of strategies that reinforce the value of care for the entire family and will be built on the linkages of the various components of Medicaid and WIC coverage already available to low-income families and the personal contacts and opportunities to personally encourage participation in health care programs that these linkages offer. AINS mailings to Health Choice and Health Check families will also be used to remind these families that the adults are probably eligible for the family planning waiver. (Please see the response to question 14 for more details about how recruitment will be conducted and phased in.)

In response to the question concerning what is being provided to men and women through this project that they do not already receive through the current infrastructure, the answer related to women is that they will receive the same comprehensive services currently available in local health departments through the limited funding provided by a combination of the Title X grant funds and other funding sources. Additionally, there will be a more tailored and intensive approach to contraception and more follow-up to prevent contraceptive failure for women at high-risk for unintended pregnancy as detailed above. (As mentioned previously, a list of the service packages for various types of visits is attached is included in Attachment Q-1-b). It should be noted that these services include pap smears, breast exams, and other screening services that promote a woman's health rather than merely addressing her need for contraception. Under the waiver men will be offered counseling and education on reproductive health including both contraception and STIs. Condoms will be covered as a part of the family planning service for both men and women if condoms are the method of choice. Vasectomies will also be available with the waiver—and their availability to low-income individuals is currently quite limited. Clinical STI services for both sexes will be available.

Currently low-income women and men can receive the services discussed above through local health departments in North Carolina. However, according to the Guttmacher Institute estimates, in our state only one half of the women in need of publicly subsidized family planning services and an even smaller proportion of the men in need of family planning are being served. Expansion of service eligibility through the family planning waiver will increase access by allowing women and men more options in both the public and private sectors. Expanded capacity into the private sector will allow families more choices not only of providers but also of location, site, and hours when preventive services can be accessed.

A major element of the family-centered recruitment innovation will be the emphasis on involving adult men in family planning. Although currently men are rarely served through publicly sponsored family planning clinics in North Carolina, men are served in the STI clinics in the same facilities. North Carolina's funding for family planning (including Title X, other state/Federal funding and local funding) is clearly inadequate relative to the numbers of women and men at or below 185% poverty. Under the waiver, recruitment efforts which will target both men and women and—with intensive outreach strategies—should make it possible to serve a much higher proportion of the population in need of publicly supported services.

Sterilization of both males and females over 21 will be covered by the waiver. In both cases current funding has been inadequate to meet the demands for this form of contraception. Only end-of-year "sweep-up" funds have been offered to health departments with waiting lists. (For more information on vasectomies, see the responses to question 6.)

Question **2—The** proposal seems to state that the targeted population does not have access to family planning services because there is not adequate public funding for the services—if they were available free of charge, the population would use them. What evidence/data does the state have that transportation, lack of education on how to utilize the services, and other factors will not affect the use and effectiveness of family planning services even if they are available free through Medicaid? For example, does the State have data on the use of family planning services of non-pregnant women ages 18 to **44** that are Medicaid eligible through some other coverage group? Does the State have data on the failure rate of family planning methods for these women?

The State Family Planning Program staff believes that inadequate public funding for family planning services constitutes a significant barrier to low-income individuals receiving needed services that could reduce our unintended pregnancy rate. The importance of eligibility expansion in increasing utilization of health care is apparent when we look at the data in attached tables showing the dramatic increases in participation in Health Check and Health Choice subsequent to the marketing of these programs. (Attachment Q-2-a) In the Health Check Program, year-to-year comparisons

show that the number of enrolled children and participation increased from 151,331 in 1992/93 to 236,307 in 1998/99. Similarly, enrollment in North Carolina's Health Choice Program showed increases from 5,981 in 1998 to 67,231 in 1999. The Baby Love Program showed similar increases in utilization apparently tied to major increases in public funding expanding' eligibility. (It should be noted, however, that extensive efforts at recruitment in all three of these programs were utilized and these efforts appear to have been very important—in addition to the expanded eligibility—in producing the program expansion.)

The same families that demonstrated a willingness to use Health Check, Health Choice and Baby Love will be the first families targeted for participation in North Carolina's family planning waiver. The Health Check and Health Choice recruitment campaigns in our state have been among the most successful campaigns in the country. Thus, we believe that targeting these families for the family planning waiver will result in similar growth in family planning participation.

National data suggest that the cost of family planning services is one of the major barriers to contraceptive usage. A recent report prepared by the Alan Guttmacher Institute entitled "US Policy Can Reduce Cost Barriers to Contraception" reports that

> One of the major barriers to universal contraceptive access in this country is that contraceptives can be expensive. For example, costs for supplies alone can run approximately $360 per year for oral contraceptives, $180 per year for the injectable, $450 for the implant and $240 for an IUD. In addition, the bulk of the cost for some of the most effective methods must be paid up front,
> (from the Alan Guttmacher website, July, 1999)

Another article published in Family Planning Perspectives (March/April, 1999) entitled "Contraceptive Failure Rates: New Estimates from the 1995 National Survey of Family Growth" concludes that income has a strong influence on contraceptive failure rate. Access barriers as well as other disadvantages associated with poverty seriously impede contraceptive practice. The article went further to rank reversible contraceptive methods by effectiveness over the first 12 months of use. The ranking from the lowest failure rates to the highest are as follows: implants, injectables, pills, diaphragm and cervical cap, male condom, periodic abstinence, withdrawal, and spermicides.

However, the Family Planning Program does not assume that other barriers such as lack of transportation or lack of choice in providers are insignificant factors affecting the successful recruitment and retention of program participants. In fact, biennial community assessments performed by North Carolina's local health departments often contain documentation that transportation—particularly in our more rural counties—can be a major barrier to eligible clients taking advantage of the public health programs that are available to them. Lack of public transportation is often addressed to some degree by vans purchased by local departments of social services or general purpose county government. It is our hope that with the waiver supporting the clinical services of a large proportion of family planning patients whose services are currently supported by county

funds, counties will be able to invest more local funds in the provision of transportation to these services. Also, in those counties with extensive public transportation already available, county funds could be used to provide vouchers for transportation. Contractual agreements between the NC Family Planning Program and local health departments reveal that in CY 1999 over one-fourth of the cost of providing family planning services to low-income clients came from local funds. With implementation of the waiver, the state program will require that each health department develop a plan for providing support services such as transportation and for assuring reasonable access for working people by extending or maintaining nontraditional clinic hours and/or alternative service sites. Finally, increasing access to private providers through the waiver should provide some positive impact on the transportation problem as it will increase access to private providers and multiple sites—some of which will be more convenient than local health departments.

Lack of education on how to utilize services is often a significant barrier. The plan for recruiting and retaining clients (see the responses to question 1 and 14) focuses on incrementally building on the successful participation rates of such programs as Medicaid for Pregnant Women, Health Choice, Health Check, and WIC. We believe that this strategy will assist **us** in efficiently expanding and maintaining the family planning patient base.

Question 3---Please clarify the eligibility determination process. From the proposal, it appears that family size for the needs standard will include parents, spouse, and other children under 21, but the income of these individuals will not be counted, Parental income for individuals under 21 will not be counted. Will parents' needs be included regardless of age, or only for those under 21? Will the spouse's income be counted? On page **6,** the State has indicated that the same income deductions will be applied as for the MPW category; however, on page 23 the State requests a waiver of sections **1902**(a)(**17**) and **1902**(a)(**10**) and the regulation at 42 CFR 435.100 and 435.602 in order to base income eligibility solely on gross income. This seems inconsistent.

Parents needs are included if recipient is 19 or 20 and living in the home. Spouses income will be counted. We will evaluate a couple's income as we currently do for MPW. The reference on page **23** has been removed. The same income deductions will apply as for the MPW category.

Question 4---Please clarify the duration of peoples' eligibility. The proposal says that redetermination of eligibility will be required every year and then it discusses the requirement for individuals to report changes in income. What does it mean that the target population will receive Medicaid coverage of family planning services for no less than the entire project period when eligibility will be redetermined every year? Please confirm that yearly determinations will be performed by the State in addition to the requirement for enrollees to self-report income changes.

The reference on page 6 of the waiver proposal under the heading of "Service Delivery" was incorrect and has been removed. Yearly determinations for continued eligibility will be required of people enrolled under this waiver program as well as the requirement for recipients to self-report any changes in income. Eligibility will be for a 12-month period. We will do a yearly redetermination. The sentence stating that the target population will receive Medicaid coverage for family planning services for no less than the entire project period has been removed.

Question 5---The proposal describes a number of services as "family planning services" that are not viewed as family planning services by Medicaid and therefore, not eligible for the enhanced 90% family planning match. The attached document explains the services that are entitled to a 90% match. We will go over the services that you are requesting to include in the waiver and advise you as to which ones are eligible for the 90% match rate and which ones are eligible for the regular match rate. What follows are some guidelines based on the services that were discussed in the proposal.

The State has clarified services that are matched at the enhanced rate in the services section of the Family Planning Waiver. The clarifications are as follows:

Services Covered At The Enhanced Rate:

A. Family Planning initial or annual examination
B. Family Planning Counseling visits
C. Family Planning Supply visit
D. **All** FDA approved and Medicaid covered methods of birth control
E. Tubal ligations and vasectomies and necessary post-procedure follow-up when the recipient is a minimum of 21 years of age
F. Pregnancy test when performed as part of a package of evaluative family planning services to determine whether or not contraceptives are contraindicated, and when the patient may have used contraception improperly and pregnancy is suspected.
G. Laboratory tests that are in conjunction with the family planning visit.
H. Pap smears when provided as part of a family planning encounter.
I. Screening, testing, and counseling related to HIV or STIs when performed as part of a part of a package of STI tests provided to women and men in conjunction with family planning encounter. By encounter we mean a visit to discuss and obtain family planning services. These encounters would typically include a medical exam, routine laboratory testing, including pregnancy and STI testing, counseling and the prescription of a family planning method if desired.

Services Covered At The Regular Rate:

A. Evaluation and management visits for STI diagnosis, treatment and follow-up.
B. Antibiotics for STIs
C. HIV testing when not done in conjunction with a family planning encounter.
D. Hepatitis B immunizations
E. Pregnancy test when not performed as part of a evaluative family planning service.
F. Pap Smears that are not performed as part of a family planning encounter.
G. Colposcopies with or without biopsy

Question 6—The State is including men over age 18 in this waiver, with emphasis on the availability of vasectomies. What specific outreach strategies are planned for this population? On page **4** of the waiver proposal, the State indicates that there is a pent up demand for sterilization services in health departments across the State for both men and women. Does the State have more information on the number on the waiting lists specifically for vasectomies? Does the State plan to exclusively target males for vasectomy services, or does it plan to conduct outreach to males for obtaining family planning services in general (counseling visits and the use of condoms? Will condoms be included in the supply visits? Since men who are not normally Medicaid eligible are included in the target population, this demonstration could evaluate not only the effectiveness of family planning education for men, but also the effectiveness of education about HIV/AIDS and other STIs. This is where the difference in focusing on vasectomies versus the use of condoms should be noted. The State should clarify exactly what it is they expect to learn from the coverage of men in this waiver.

The North Carolina family planning waiver includes coverage for both males and females. This inclusion reflects our goal of treating the family unit holistically. Outreach efforts will not be gender specific. As outlined in the response to question 14, one of our first and primary target populations will be the parents (both male and female) of the Health Check and Health Choice children. Also, we envision continuing coverage of clients (both males and females) as they age out of the these programs at age I8 in order to provide family planning services as needed to this population which should have already developed the habit of seeking preventive health services. Recruitment efforts will advise males of the availability of condoms, education and counseling concerning HIV/AIDS and other STIs through the family planning program with a strong prevention emphasis. Condoms will be included in the supply visits as resources permit.

The availability of vasectomy services through referral will be an important component of the program. Currently, there is not a systematic method to determine unmet need for vasectomy services statewide; nor is there a dedicated item in the state's family planning budget to support sterilization for males or females. Any funds which can be identified half-way through a budget year are made available for this purpose, and county health departments are encouraged to develop lists of clients who have requested sterilization. Publicly funded vasectomies have been performed through the Guilford Vasectomy Program in order to assure that fees are negotiated to the lowest possible level, that

appropriate counseling takes place, and that patients are charged based on a sliding fee scale. Because the funds the state has been able to invest in this effort are so limited, vasectomies have not been marketed to the general public. Only patients who have requested the services are placed on the list.

In recent years the Guilford Program has been able to arrange vasectomies for between 200 and 350 annually—depending on the amount of "sweep-up" funds the state program has been able to identify. The state staff and the Guilford staff believe that many more vasectomies could be performed if funding was more predictable and stable and if the availability of this service could be marketed directly to low-income individuals statewide. (Also, it should be noted that no marketing or needs assessment has been done for female sterilization.)

Finally, in reference to the second part of this question, although vasectomies will be a major focus of the project, males will be counseled concerning other forms of contraception as well. As stated earlier, condoms will be provided as resources permit. Appropriate education and consent will be provided at each visit. However, it is not the intent of this program to study and evaluate the effectiveness of family planning or HIV/AIDS and STI education provided to male participants.

Question 7---Is transportation a benefit under this program?

Transportation is not a benefit under this program.

Question 8---It is indicated that minors may sign a consent form but will be counseled about the importance of discussing birth control needs with parent(s). Does this mean there is not state law that requires parental involvement?

Minors are not included in the waiver.

Question 9---The evaluation design needs to be detailed and designed in order to determine the impact of this project. It is important that the evaluation isolates the impact of this demonstration from other family planning initiatives occurring in the State. Please discuss the design of the evaluation and who is going to conduct the evaluation. If a contractor is conducting the evaluation it is acceptable to receive the full design report after the project has been approved.

A contractor will perform the evaluation. An evaluation team of three individuals (Neva Edens-Bartholomew MD, MPH; Merry-K Moos FNP, MPH; and Cathy Melvin PHD, MPH) have been established for this purpose. This group will work through the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, where Dr. Melvin serves as a Senior Research Fellow and Director of the Child Health Services Program. They will be given full support from Dr. Paul Buescher, the head of the Statistical Services Unit at the State Center for Health Statistics. His office will provide necessary data to the Sheps Center for the evaluation, and he will serve in a consultant role for the project.

The contractor will under take a retrospective cohort study and a process evaluation. The retrospective cohort study involves secondary data analyses of information routinely obtained at the State Center for Health Statistics. These data sources include the Pregnancy Risk Assessment Monitoring System (PRAMS), the Behavior Risk Factor Surveillance System (BRFSS) and vital records and other administrative data on all Medicaid recipients of childbearing age. To the extent possible, linkages among these data sets will be performed. The process evaluation will be based on the RE-AIM model in which the Reach, Efficacy, Adoption, Implementation and Maintenance of public health interventions are assessed using interviews, focus groups and surveys.

The evaluation team will submit annul reports of the ongoing evaluation as well as summary reports at the end of the third and sixth year.

Question 10--In the evaluation process, the proposal is to identify all Medicaid births, then identify the women who had received family planning services under the waiver and those who had not to compare birth outcomes and spacing. This proposal does not appear to take into consideration that within the group of births to women who did not receive waiver services is a subgroup of women who did have access to free family planning services. These are women who were continuously eligible for Medicaid as a caretaker or some other group other than pregnant women. Thus, the statement on page 17 that almost all of the women who identify Medicaid as their payment source for pregnancy services may have also been eligible for Family planning Waiver program services may not be entirely accurate. The State may wish to compare this group separately.

This section in the waiver has been corrected to reflect that some of the women who identify Medicaid as their payment source for pregnancy services may have also been eligible for family planning waiver services.

Question 11--Is the State committing to administering a "male version" of the BRFSS family planning module as suggested on page 19? Also, on page 20 in discussing the process evaluation tool, there is no commitment that the State will use this tool.

The State is committing to administering a "male version" of the BRFSS family planning module as suggested on page 19. The State Center for Health Statistics will began using the male version in January 2002. The State has committed to using the BRFSS family planning module on page 20.

Question 12--Please Clarify who is in the target population and how many people will be covered in the program.

So as not to overlap with the current NC CHIP program eligibility (NC Health Choice) population, this program will cover all men and women over age 18 who are at or below 185% of the federal poverty level. The program will cover 79,934 people.

Question 13--In listing the initiatives that have access to the potentially eligible population, the State lists Intensive Home Visiting Projects. This project had been submitted as a state plan amendment, but was subsequently withdrawn. The State indicated that the Legislature no longer supported it. Please discuss this discrepancy.

Although, during the most recent NC Legislative Session (2000), there was no support for Medicaid reimbursement for Intensive Home Visiting services, these projects and services still exist and are an integral piece of a continuum of services offered to pregnant and parenting families in North Carolina. At this time, the majority of the projects are housed within public health agencies in the counties, thus interact with existing maternal and children's services. These projects are receiving grant funds and the plan is to approach the Legislature again regarding Medicaid reimbursement for services during the next session. We continue to believe that people working with families in these projects are important in the marketing and outreach for the waiver program.

Question 14--The plans for developing an outreach, education and marketing plan are unclear. The State should provide more detail prior to the approval of the waiver. Also, it appears the targeting of the various populations will be phased in—initially families and women previously on Medicaid because of pregnancy; then men and women previously unaware of Medicaid programs, and finally low-income populations in general. The State should provide a timeline for the targeting of these populations over the life of the waiver. This affects the time remaining for evaluation.

(Please see the responses to question number 1 for additional details on the outreach, education and marketing of the waiver.)
As stated earlier, North Carolina's plans for recruiting clients are related to the second innovation proposed in the waiver—addressing families holistically. Recruitment efforts will first be targeted to the following groups: parents of Health Check and Health Choice children, young adults aging out of the Health Check and Health Choice programs at age 18, and women who have given birth while on Medicaid for Pregnant Women as well as their partners. In the case of Health Choice, the entire population will not be eligible for family planning—only that segment that is at or below 185% poverty. (However, parents between 185% and 200% poverty will be offered family planning services on a sliding fee scale, utilizing Federal Title X funds with services available through Title X-funded sites throughout the state.) The timeline planned for recruitment follows:

> First six months after waiver approval—Development of statewide council, marketing materials and plans to promote new eligibility for family planning. Recruitment efforts will begin immediately with MPW and Health Check/Health Choice families. Also, during the first six months of the waiver implementation, a state-level advisory board will be established to make recommendations concerning recruitment of both clients and providers in the public and private sector. The board will be comprised of both public and private health care leaders representing statewide and local organizations. The board will

serve as a liaison to the private sector and will play a key role in educating private providers on matters such as client eligibility for the waiver and services covered under the waiver.

Brochures, posters', and letters will be designed, printed and distributed. Local health department staff will receive mailings on the waiver and will be offered training in the new family planning eligibility, enrollment, waiver philosophy, visit components, etc. (Training is a very important step as the capacity of local staff to personally encourage and continue to support individuals currently on MPW and Health Check/Health Choice parents to take advantage of their new eligibility for family planning will be one of the most powerful recruitment tools. The Division of Public Health staff position included in the waiver proposal will assume the responsibility for training local staff and supporting staff throughout the state in recruitment activities.) Each health department will be required to submit its plan for recruitment which will include the specific names of staff responsible for educating parents about the family planning waiver eligibility, its plans for any mailings, the use of posters, brochures, staff identified to work with private sector to promote their involvement in recruitment, and creation of incentives to patients to take advantage of the new waiver. **A** plan will also identify ongoing efforts to make teens currently on Health Check/Health Choice aware that they will be eligible for family planning at the age of 18. The Healthy Start Foundation and the Health Check-Health Choice Hotline which have been important components of the recruitment infrastructure will also be utilized in recruitment of family planning waiver clients.

Second six months after waiver approval. Emphasis on MPW continuation eligibility for family planning and on Health Choice/Health Check parent eligibility. Brochures and letters will be distributed both by mail and by personnel in local health departments to all three of these groups. Personal recruitment will also take place through hospital visits, home visits, office visits, and telephone calls during the 60 days postpartum visit following an MPW delivery. Local staff and state staff in Raleigh and at the regional level will monitor this process and offer technical assistance and additional training as needed to strengthen the continuing personalized recruitment activities. State and regional staff will conduct training for WIC staff and staff of family physicians, multi-specialty group practices, managed care organizations and other sites at which both family planning services and child health services are likely to be offered. Training will also be conducted in health departments as necessary to train new staff. Mailings will be sent to the target populations. During this period local health department staff will develop marketing plans for the next phase of recruitment involving low-income populations not currently receiving WIC of Medicaid services.

During the third six months following approval of the waiver. WIC sites and the non-health-department staffs mentioned above will begin advising clients and patients of their new family planning eligibility. Training will continue to

assure that new staff at any of the sites being used for recruitment receive training. Letters and brochures will be sent out to all of the groups targeted in the first and second six months. During this period the program will also begin marketing family planning eligibility to low-income populations in general. Local health department staff will implement the recruitment plans developed during the previous six months. Recruitment activities might include such strategies as sending outreach workers into beauty shops, recreational facilities, and other nontraditional sites frequented by the target population.

Throughout the period of the waiver, recruitment will continue with all of the groups listed in the timeline. Emphasis will continue to be on personal recruitment by staff who know the newly eligible individual to the extent that is possible. Training for staff in both the public and private sector will continue as well.

Timeline tables for both innovations are displayed in the third attachment to this e-mail document. Note that this is an Excel document. (See Attachments Q 14-a)

Question 15--The State should describe the nature of the relationship between the Medicaid agency and the NC Center for health Statistics with regard to the use of Vital Statistics. Our budget neutrality provisions will require that you obtain birth rate data from your Office of Health Statistics. Some of this data will be due very shortly after the approval of the demonstration. We need to assure that you ill be able to access this information in a timely manner. Please provide these assurances (e.g., a data sharing schedule or process to allow for timely data sharing)

We have a Memorandum of Understanding (MOU) with the NC State Center for Health Statistics (paper copy attached). We provide some funding for their staff to complete reports for us on a regular basis. Gathering information from Vital Records will be no problem for us.

Question 16--Please complete the attached worksheet on budget neutrality.

The completed budget neutrality worksheet is attached.

Question 17--The budget sheets for each year of the waiver show the total annual recipient months increasing, yet, the recipient months for family planning services never increase. Please explain this. Also, the page that list the family planning services, amount paid, average recipient cost, etc., does not indicate the time period for the data. Also, it is not clear how a little over 34% of the recipients had a family planning visit, but over **55%** got drugs. Are the drugs duplicated or can they get drugs without a visit? It is unclear how they projected the additional Medicaid eligibles or demonstrated cost neutrality.

Recipients can get family planning drugs without a visit. Your other concerns referenced in question 17 are answered by the attached budget neutrality worksheets.

Question 18--The Child Support waiver requested under "Other restrictions" is a concern. How will the State comply with the reporting requirements? Child Support reporting requirements within the Medicaid program apply to all 1115 programs.

The Family Planning Waiver will follow 42 CFR 435.61 0. and require referrals to child support enforcement agency when the applicant is a caretaker of minor children who are Medicaid recipients and there is an absent parent. Also, referrals to child support will be required if the applicant is 19 or 20 years old, has an existing support order established before age 18 and is attending primary or secondary school.

This has been corrected on page 23 of the waiver to state that recipients applying for Family Planning Waiver Services need to cooperate with the local child support enforcement agency in establishing paternity and securing medical and child support for any minor children in the home who are Medicaid recipients. Applicants that are independent children 19 or 20 years old that have an existing support order established before age 18, are still in high school and requesting assistance under this aid program/category will be referred to the Child Support enforcement Agency.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FINANCIAL OPERATIONS

INPUT DATA

Model Budget Neutrality Worksheet for :								
FILL IN THE SHADED CELLS		2000	2001	2002	2003	2004	2005	2006
All Costs								
WITHOUT WAIVER								
BASIC FP SERVS -- All current eligibles	Persons	65,413		69,074	70,980	72,939	74,952	77,021
	Per Capita	$ 307.18						
	Total	$ 20,093,834						
DELIVERIES	Persons	47,385						
	Per Capita	$ 4,858.14						
	Total	$ 230,203,038						
FIRST YEAR COSTS	Persons	61,788						
	Per Capita	$ 4,166.27						
	Total	$ 257,425,295						
TOTAL BASE YEAR		$ 507,722,167						
WITH WAIVER								
SYSTEMS CHANGES				$ 240,000	$ -	$ -	$ -	$ -
PUBLIC AWARENESS				$ 260,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000
EVALUATION				$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000
EXPANDED FP	Persons	0		3,916	10,369	14,678	17,808	19,701
	Per Capita	$ 307.18						
	Total	$ -						
PARAMETER ASSUMPTIONS								
ADMINISTRATIVE FMAP	50.00%	75%		61.71%	61.27%	61.04%	60.80%	60.55%
REGULAR FMAP - NC								
FP FMAP =	90.00%							
PMPM COST TREND	10.56%	21.12%	→	788	1528	2124	2535	2825
DELIVERY REDUCTION								
DELIVERY TO 1ST YEAR PERSON FACTOR	130% CALCULATED FROM BASE YEAR							
NOTES:								

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS

INPUT DATA

(1) Data in cells C5, C7, C9, C12 & C15 from FFY 1999. This was only time frame we could use and be certain of capturing first year costs (paid claims) of all infants born within a one year period.

(2) It is impossible for there to be current data for cells C26 and C27 because we have not started providing Family Planning services to the target population. In the complete absence of any instructions, explanations or assistance regarding this workbook, we have inserted "0" people in cell C26 and the current PMPM cost of family planning services in cell C27.

(3) The computations in the "Demonstration Budget Projection" sheet for Basic FP Services with Waiver were flawed. The formulas were based upon the erroneous assumption that the number of persons receiving "Basic FP Services" will decrease when "Extended FP Services" are provided to the target population. We see no reason for this to occur. In fact the number of persons receiving family planning services has been increasing, consequently, we have changed the formula to eliminate the reduction and to reflect our projected annual increase in numbers of persons receiving these services. This population consists entirely of persons who will/would be Medicaid eligibles without the family planning waiver.

(4) The formulas in the "Demonstration Budget Projection" worksheet that calculate the reduction in deliveries due to the inclusion of a new group of eligibles are based upon the assumption that deliveries will be reduced by a fixed percentage each year. We do not believe this represents the way the reductions will occur, particularly in the first year when most of the deliveries that result from pregnancies among the target population would not occur until the second year (9 month gestation period). We have calculated the number of deliveries among the target population we believe will be averted each year and have deducted these "averted deliveries" from the projected deliveries (assuming no FP waiver) in each year.

(5) This worksheet contained two Federal match rates, 50% and 90%. In the "Demonstration Budget Projection" worksheet, in the computations of federal dollars expended, all of the family planning services were calculated at 90% federal dollars, but, everything else was calculated at 50%. This makes no sense as it greatly overstates the state "savings" and understates the federal savings. We have added a 75% federal match rate for "System Changes" to the MMIS. We have also added the Actual NC FMAP for SFY 2002 and our estimated FMAP for the subsequent years. These rates are applied to the PMPM costs of "Deliveries" and "First Year Costs".

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Model Budget Neutrality Worksheet for :								
All Costs		**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
WITHOUT WAIVER								
BASIC FP SERVS -- All current eligibles	**Persons**	65,413						
	Percapita	$ 307.18	$ 372.06	$ 411.35	$ 454.79	$ 502.82	$ 555.92	$ 614.63
	Total	$ 20,093,834						
DELIVERIES	**Persons**	47,385						
	Per Capita	$ 4,858.14	$ 5,884.18	$6,505.55	$7,192.54	$7,952.07	$8,791.81	$9,720.23
	Total	$230,203,038						
FIRST YEAR COSTS	Persons	61.788						
	Per Capita	$ 4,166.27	$ 5,046.19	$5,579.07	$6,168.22	$6,819.58	$7,539.73	$8,335.93
	Total	$257,425,295						
TOTAL BASE YEAR		$507,722,167						
WITH WAIVER								
BASIC FP SERVS	**Persons**	65,413						
	Percapita	$ 307.18	$ 372.06	$ 411.35	$ 454.79	$ 502.82	$ 555.92	$ 614.63
	Total	$ 20,093,834						
DELIVERIES	**Persons**	47,385						
	Per Capita	$ 4,858.14	$ 5,884.18	$6,505.55	$7,192.54	$7,952.07	$8,791.81	$9,720.23
	Total	$230,203,038						
FIRST YEAR COSTS	**Persons**	61,788						
	Per Capita	$ 4,166.27	$ 5,046.19	$5,579.07	$6,168.22	$6,819.58	$7,539.73	$8,335.93
	Total	$257,425,295						
EXPANDED FP	**Persons**							
	Percapita	$ -	$ 339.62	$ 375.48	$ 415.13	$ 458.97	$ 507.44	$ 561.03
	Total	$						
SYSTEMS CHANGES								
PUBLIC AWARENESS								
EVALUATION								
TOTAL WITH WAIVER COSTS		$507,722,167						
DIFFERENCE		$ -	$					

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Model Budget Neutrality Worksheet for :

All Costs		**2002**	**2003**	**2004**	**2005**	**2006**	**TOTAL**
WITHOUT WAIVER							
BASIC FP SERVS -- All current eligibles	Persons	69,074	70,980	72,939	74,952	77,021	364,966
	Per Capita	$ 411.35	$ 454.79	$ 502.82	$ 555.92	$ 614.63	
	Total	$ 28,413,436	$ 32,281,021	$ 36,675,242	$ 41,667,442	$ 47,339,361	$ 186,376,503
DELIVERIES	Persons	50,037	51,418	52,837	54,295	55,794	264,380
	Per Capita	$ 6,505.55	$ 7,192.54	$ 7,952.07	$ 8,791.81	$ 9,720.23	
	Total	$ 325,516,566	$ 369,824,312	$ 420,162,668	$ 477,353,001	$ 542,327,966	$ 2,135,184,512
FIRST YEAR COSTS	Persons	65,246	67,047	68,897	70,799	72,753	344,741
	Per Capita	$ 5,579.07	$ 6,168.22	$ 6,819.58	$ 7,539.73	$ 8,335.93	
	Total	$ 364,010,691	$ 413,557,860	$ 469,848,829	$ 533,802,262	$ 606,460,850	$ 2,387,680,493
TOTAL WITHOUT-WAIVER COSTS		$ 717,940,694	$ 815,663,193	$ 926,686,739	$ 1,052,822,705	$ 1,196,128,177	$ 4,709,241,508
WITH WAIVER							
BASIC FP SERVS	Persons	69,074	70,980	72,939	74,952	77,021	364,966
	Per Capita	$ 411.35	$ 454.79	$ 502.82	$ 555.92	$ 614.63	
	Total	$ 28,413,436	$ 32,281,021	$ 36,675,242	$ 41,667,442	$ 47,339,361	$ 186,376,503
DELIVERIES	Persons	49,249	49,890	50,713	51,760	52,969	254,580
	Per Capita	$ 6,505.55	$ 7,192.54	$ 7,952.07	$ 8,791.81	$ 9,720.23	
	Total	$ 320,390,193	$ 358,834,111	$ 403,272,471	$ 455,065,762	$ 514,868,316	$ 2,052,430,852
FIRST YEAR COSTS	Persons	64,218	65,054	66,127	67,493	69,069	331,961
	Per Capita	$ 5,579.07	$ 6,168.22	$ 6,819.58	$ 7,539.73	$ 8,335.93	
	Total	$ 358,276,717	$ 401,267,384	$ 450,958,367	$ 508,878,997	$ 575,754,349	$ 2,295,135,814
in demo → *EXPANDED FP*	Persons	3,916	10,369	14,678	17,808	19,701	66,472
	Per Capita	$ 375.48	$ 415.13	$ 458.97	$ 507.44	$ 561.03	
	Total	$ 1,470,348	$ 4,304,448	$ 6,736,915	$ 9,036,365	$ 11,053,039	$ 32,601,115
SYSTEMS CHANGES		$ 240,000	$ -	$ -	$ -	$ -	$ 240,000
PUBLIC AWARENESS		$ 260,000	$ 500,000	$ 500,000	$ 500,000	$ 500,000	$ 2,260,000
EVALUATION		$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 100,000	$ 500,000
TOTAL WITH WAIVER COSTS		$ 709,150,694	$ 797,286,964	$ 898,242,995	$ 1,015,248,566	$ 1,149,615,066	$ 4,569,544,285
DIFFERENCE		$ 8,789,999	$ 18,376,229	$ 28,443,744	$ 37,574,139	$ 46,513,112	**$ 139,697,223**

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS

DEMONSTRATION BUDGET PROJECTION

Model Budget Neutrality Worksheet for :

FEDERAL COSTS		**2002**	**2003**	**2004**	**2005**	**2006**	**TOTAL**
WITHOUT WAIVER							
BASIC FP SERVS -- All current eligibles	Persons	69,074	70,980	72,939	74,952	77,021	364,966
	Per Capita	$ 370	$ 409	$ 453	$ 500	$ 553	
	Total	$ 25,572,093	$ 29,052,919	$ 33,007,718	$ 37,500,698	$ 42,605,425	$ 167,738,853
DELIVERIES	Persons	50,037	51,418	52,837	54,295	55,794	264,380
	Per Capita	$ 4,015	$ 4,439	$ 4,907	$ 5,426	$ 5,999	
	Total	$ 200,884,411	$ 228,227,828	$ 259,292,886	$ 294,586,471	$ 334,684,146	$ 1,317,675,742
FIRST YEAR COSTS	Persons	65,246	67,047	68,897	70,799	72,753	344,741
	Per Capita	$ 3,443	$ 3,807	$ 4,209	$ 4,653	$ 5,144	
	Total	$ 224,640,098	$ 255,216,895	$ 289,955,459	$ 329,422,721	$ 374,262,152	$ 1,473,497,324
TOTAL WITHOUT-WAIVER COSTS		$ 451,096,601	$ 512,497,642	$ 582,256,063	$ 661,509,890	$ 751,551,723	$ 2,958,911,919
WITH WAIVER							
BASIC FP SERVS	Persons	69,074	70,980	72,939	74,952	77,021	364,966
	Per Capita	$ 370	$ 409	$ 453	$ 500	$ 553	
	Total	$ 25,572,093	$ 29,052,919	$ 33,007,718	$ 37,500,698	$ 42,605,425	$ 167,738,853
DELIVERIES	Persons	49,249	49,890	50,713	51,760	52,969	254,580
	Per Capita	$ 4,015	$ 4,407	$ 4,854	$ 5,345	$ 5,885	
	Total	$ 197,720,798	$ 219,840,193	$ 246,160,599	$ 276,674,642	$ 311,742,385	$ 1,252,138,617
FIRST YEAR COSTS	Persons	64,218	65,054	66,127	67,493	69,069	331,961
	Per Capita	$ 3,443	$ 3,779	$ 4,163	$ 4,584	$ 5,047	
	Total	$ 221,101,519	$ 245,836,994	$ 275,268,434	$ 309,392,457	$ 348,607,651	$ 1,400,207,055
EXPANDED FP	Persons	3,916	10,369	14,678	17,808	19,701	66,472
	Per Capita	$ 338	$ 374	$ 413	$ 457	$ 505	
	Total	$ 1,323,314	$ 3,874,004	$ 6,063,223	$ 8,132,728	$ 9,947,735	$ 29,341,004
SYSTEMS CHANGES		$ 180,000	$ -	$ -	$ -	$ -	$ 180,000
PUBLIC AWARENESS		$ 130,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 1,130,000
EVALUATION		$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 250,000
TOTAL WITH WAIVER COSTS		$ 446,077,723	$ 498,904,110	$ 560,799,974	$ 632,000,525	$ 713,203,197	$ 2,850,985,529
DIFFERENCE		$ 5,018,878	$ 13,593,532	$ 21,456,089	$ 29,509,364	$ 38,348,527	**107,926,390**
ADMINISTRATIVE FMAP	50%	75%					
REGULAR FMAP	61.71%	61.27%	61.04%	60.80%	60.55%		
FP FMAP =	90%						
PMPM COST TREND	10.56%						

1. Last Name First Name MI

2. Patient Number

3. Date of B
Day Month Year

4. Race 1. White 2. Black Ethnicity: Hispanic Origin?
3. Am. Ind. 4. Other 1. Yes 2. No

5. Sex 1. Male 2. Female

6. County of Residence

Attachment Q1-a
North Carolina Department of Health and Human Services
Division of Public Health

Intendedness Risk Assessment Tool

1. How would you describe your desire for pregnancy? Using the scale below, circle the number to the right after each statement to indicate how strongly you agree or disagree with that statement.

		Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*
a.	I want to get pregnant now	1	2	3	4
b.	I want to be pregnant in the near future	1	**2**	3	4
c.	I do not want to be pregnant in the near future	**1**	2	3	4
d.	I do not ever want to be pregnant	1	2	**3**	4
e	I don't know whether or not I want to get pregnant	1	2	3	4

2. 'There are many methods available to help prevent pregnancy and these methods are usually referred to as birth control methods or contraceptive methods. Have you used any of the following methods of birth control in the past 30 days? *(Check **all that apply**)*

☐ Condoms
☐ Diaphragm
☐ Sponge
☒ Foam, jelly, spermicide cream, or film

How often did you use these methods?
☐ Every time I had intercourse
☐ Almost every time I had intercourse
☐ Sometimes when I had intercourse
☒ Almost never when I had intercourse
☒ Never when I had intercourse

☒ **IUD**
☒ Depo-Provera
☒ Norplant

☒ Birth control pills

How often did you take your pill?
☒ Same time every day
☒ Every day, but not at the same time
☐ Most days (missed 1 or 2 days)
☐ Some days (missed 3 to **5** pills)
☒ Not very often (missed more than **5** pills)

☒ Withdrawal
☒ Rhythm method
☒ Emergency method
☒ Some other method: ***please specify***

_____

☒ None

3. In the next 30 days, how sure are you that you will use a method of birth control to prevent pregnancy EVERY time you have intercourse?

☒ Very sure I will

☒ Somewhat sure I will

☒ Somewhat sure I won't

☒ Very sure I won't

☒ I want to get pregnant, so I won't use any birth control

4. Circle the number that best describes how each statement applies to you. (1=not at all true for me *to* 5=completely true for me)

	Not at all true				Completely true
a. There are times when I could be so involved sexually or emotionally that I could have sex without using any birth control.	1	2	3	4	5
b. It would be embarrassing for me to go to a drugstore and buy foam or condoms or get a pill prescription filled.	1	2	3	4	5
c. There are times when I should talk to my partner about using contraceptives, but I can't seem to do it.	1	2	3	4	5

5. Please answer each of the following:

a. How many sex partner(s) have you had in the past *6* months? ☒ 1 ☒ 2 ☒ 3-4 ☒ more than4

b. Have you ever been tested for a sexually transmitted disease (STD), such as chlamydia or gonorrhea or for HIV (the infection that causes AIDS)? ☒ No ☒ Yes Eldon'tknow

c Has your partner(s) ever been tested for an STD, such as chlamydia or gonorrhea or **HIV?** ☒ No ☒ Yes Eldon'tknow

d. Have you ever had an STD, such as chlamydia or gonorrhea? ☒ No ☒ Yes Eldon'tknow

e. Do you currently have an unusual discharge from your vagina, warts or sores in your vagina or vulva, pain while urinating, or continued pain in your abdomen? ☒ No ☒ Yes

6. In the next 30 days, how sure are you that you will use a condom to prevent getting a **STD** or HIV EVERY time you have intercourse ?

☒ Very sure I will

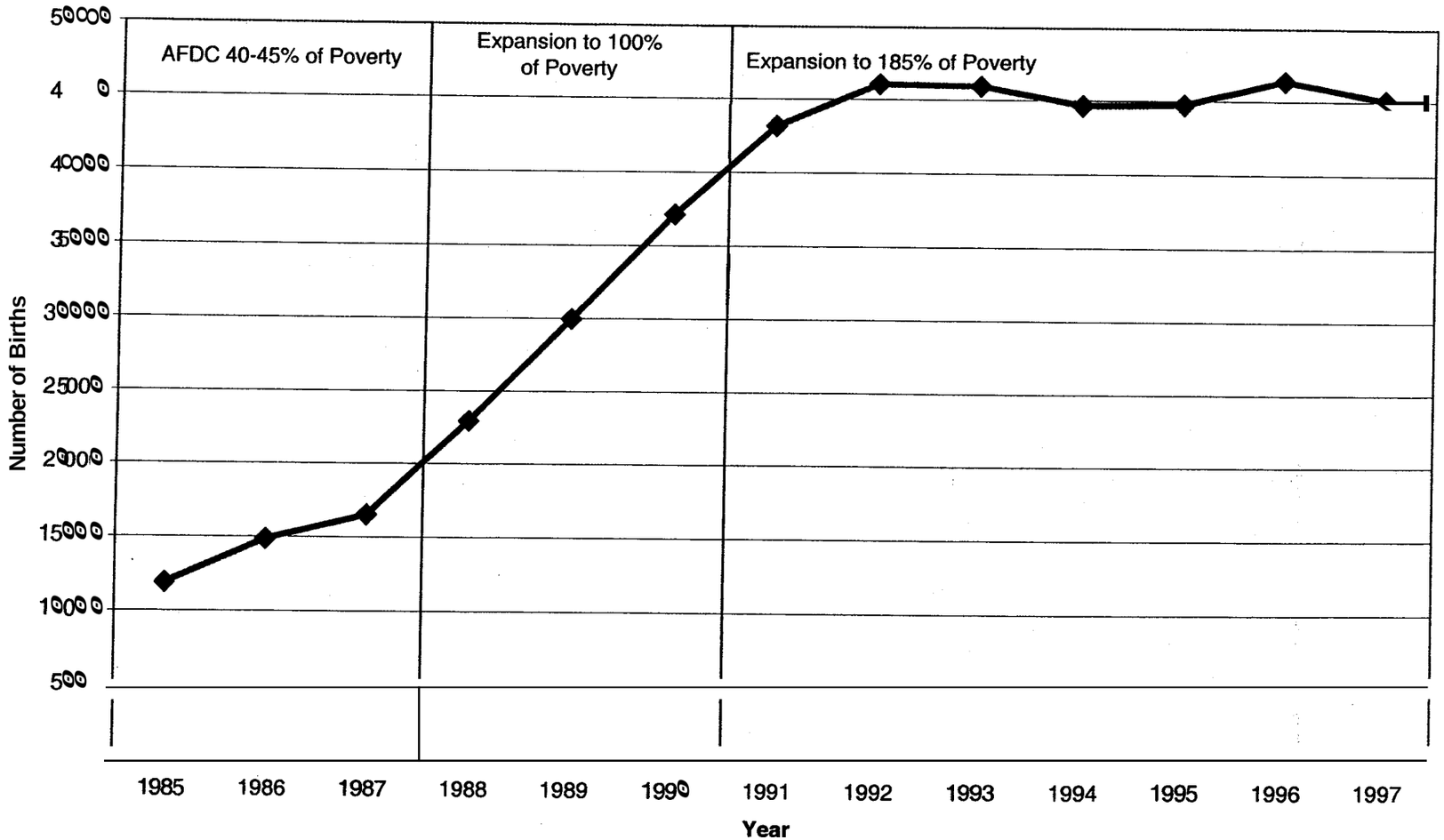
☒ Somewhat sure I will

☒ Somewhat sure I won't

☒ Very sure I won't

☒ I am not at risk of **STD** or HIV so I will not use a condom for this reason

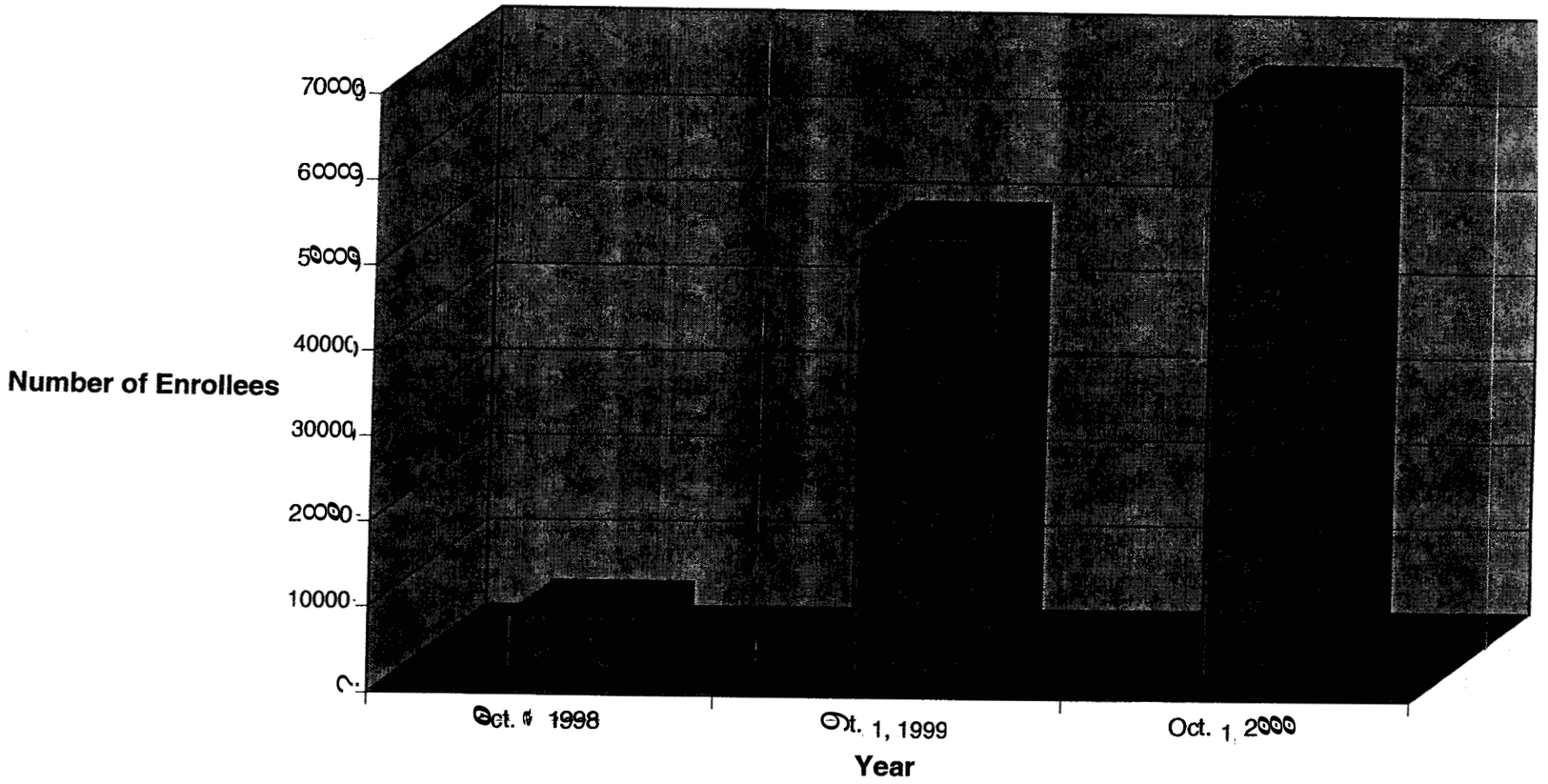
Attachment Q2-a.
Births Paid by Medicaid Expansion



Attachment Q2-a Births Paid bv Medicaid Exuansion

1985	11,890
1986	14,855
1987	16,506
1988	22,957
1989	29,972
1990	37,139
1991	43,191
1992	46,037
1993	45,911
1994	44,659
1995	44,756
1996	46,361
1997	45,078

Attachment Q2-a.
Enrollment in NC Health Choice for Children



Attachment Q2-a Number of Medicaid Enrolled Children in Health Check Proqram

92/93	151,331
93/94	
94/95	
95/96	
96/97	213,030
97/98	229,657
98/99	236,307

ATTACHMENT Q1-b

REQUIREMENTS AND RECOMMENDATIONS OF THE NORTH CAROLINA STATEWIDE FAMILY PLANNING PROGRAM FOR ROUTINE CONTRACEPTIVE MANAGEMEN"

I U D

The following is a summary of the contents of the "Minimum Requirements for Routine Contraceptive Management "as defined by the Federal Title X and the Women's Preventive Health Branch Guidelines. Additional services may be provided based on the medical judgement of the clinician providing the services.

X = Required **(X)** = If indicated

	Initial Visit'	Limited Revisit within 3 months of insertion	Extended Revisit everyevery 12 months (Review and Update)	Complete Physical 24 months
A. History				
1. General	X			X
2. Family History	X		X	X
3. Method Specific		X	X	X
B. Physical				
1. General Physical **Exam** including these specific services				
a. Weight	X		(X)[3]	X
b. Height	X		(X)[3]	(X)
c. Blood Pressure	X	(X)[2]	X	X
d. Extremities	X		(X)[3]	X
e. Breast	X		(X)[3]	X
f. Abdomen	X		(X)[3]	X
g. Pelvic **Exam**	X	(X)[2]	X	X
h. Heart and Lungs	X		(X)[3]	X
i. Thyroid	X		(X)[3]	X
2. Method Specific		IUD Check		
C. Lab[4]				
1. Hct. Or Hgb.	X	(X)[2]	X	X
2. Urinalysis	(X)		(X)[3]	(X)
3. Pap Smear	X		X	X
4. GC	X		X	X
5. Serology	X		(X)	(X)
6. Immunity Assessment	X	(X)	(X)	(X)

ATTACHMENT Q1-b

REQUIREMENTS AND RECOMMENDATIONS OF THE NORTH CAROLINA STATEWIDE FAMILY PLANNING PROGRAM FOR ROUTINE CONTRACEPTIVE MANAGEMENT

NON-PRESCRIPTIVE METHODS

The following is a summary **of** the contents of the "Minimum Requirements for Routine Contraceptive Management "as defined by the Federal Title **X** and the Women's Preventive Health Branch Guidelines. Additional services may be provided based on the medical judgement of the clinician providing the services.

X = Required **X) = If** indicated

	Initial Visit'	Extended Revisit every 12 months	Complete Physical every 24 months
A. History		(Review and Update)	(Review and Update)
1. General	X	X	X
2. Family History	X	X	X
3. Method Specific	X	X	X
B. Physical			
1. General Physical Exam including these specific services			
a. Weioht	X	(X)[3]	X
b. Height	X	(X)	(X)
c. Blood Pressure	X	(X)[3]	X
d. Extremities	X	(X)[3]	X
e. Breast	X	(X)[3]	X
f. Abdomen	X	(X)[3]	X
0. Pelvic Exam	X	(X)[2,3]	X
h. Heart and Lungs	X	(X)[3]	X
i. Thyroid	X	(X)[3]	X
C. Lab[4]			
1. Hct. Or Hgb.	X	(X)[3]	X
2. Urinalysis	(X)[5]	(X)[3]	(X)[5]
3. Pap Smear	X	X	X
4. GC		(X)[3]	
5. Serology	X	(X)	(X)
6. Immunity Assessment	X		(X)
D. Education and Counseling	X	(X)	(X)

Attachment Q1-c

Project Timeline

North Carolina Family Planning Intervention to Reduce Unintended Pregnancy And Pregnancy Related Costs Among High Risk Family Planning Clients in Five Intervention County Clinics vs Clients in Five Control Counties

Activities	Time-line	Intervention Counties Clients		Control Counties Clients
Family Planning Client's Risk of Unintended Pregnancy		**High Risk**	**Lower Risk**	**All**
1.Enroll Health Check/Health Choice/MCC parents into FP		X	X	X
2.Initial FP clinic visit a. Identify those FP clients at risk for unintended pregnancy	0 mos.	X	X	X
b. Provide most appropriate FP method		X	X	X
c. Provide tailored counseling during the clinic visit		X	X	X
3.Tailored counseling call #1 & referral if needed	1-11 mos.	X		
4. Tailored counseling call #2 & referral if needed		X		
5. Return clinic visit as needed		X	X	X
6.Tailored counseling call #3 & referral if needed		X		
7. Annual clinic visit	12 mos.	X	X	X
a. Provide tailored counseling		X	X	X
8.Tailored counseling call #4 & referral if needed	13-23 mos.	X		
9.Tailored counseling call #5 & referral if needed		X		
10.Return clinic visit as needed		X	X	X
11. Tailored counseling call #6 & referral if needed		X		
12.Annual clinic visit	24 mos.	X	X	X
13.Data collection & evaluation	24+mos.	X	X	X

Attachment Q14-a

North Carolina's Family Planning
1115 Waiver Project Timeline

	Year I	Year II	Year III	Year IV	Year V
Innovation I (Tailoring Family Planning Services)					
1. Five-County Inte[illegible]	X	X			
2. Evaluation			X		
3. Statewide Implementation				X	X
Innovation II (Recruiting Priorities *)					
1. Establish Statewide Council and Develop Marketing Materials	X ==>	==> ==>	==> ==>	==> ==>	==> ==>
2. Target Health Choice/Health Check Parents and Former MPW's	X	==> ==>	==> ==>	==> ==>	==> ==>
3. Target WIC Parents and Utilize Staff in Appropriate Non-LHD Settings for Recruitment		X ==>	==> ==>	==> ==>	==> ==>
4. Evaluation of Recruitment	X	X	X	X	X

* All of the groups targeted for recruitment (parents of Health Choice/Health Check participants, Health Choice/Health Check participants, MPW's, etc.) will be eligible throughout the waiver; however, groups have been targeted for priority recruitment as shown in the timeline.

INTERAGENCY MEMORANDUM OF UNDERSTANDING (MOU)

between

The Division of Medical Assistance

and

The State Center for Health Statistics

for

Costs of Medicaid Data Reporting and Analysis Support

This MOU is a supplement to the "Interagency Agreement Between the Division of Medical Assistance Department of Human Resources and the Department of Environment, Health, and Natural Resources (DEHNR)" dated 9/11/92. All elements of the original agreement not inconsistent with this more recent MOU remain in effect.

The Division of Medical Assistance (hereafter referred to as "DMA") desires to continue to use the services of the State Center for Health Statistics (hereafter referred to as "the State Center") for Medicaid data reporting and analysis functions. The services that the State Center will provide and for which DMA will claim and pay the State Center the Federal Financial Participation (FFP) amount are detailed below. General categories of effort are listed below. Specifics of how this will be accomplished are prescribed in later portions of this MOU.

1. Ongoing statistical/spatial analyses of desired policy and program issues related to service utilization, cost, and outcomes of Medicaid clients being served in North Carolina.

2. Assistance in developing the use of Historically Black Colleges and Universities in conducting statistical/spatial analyses of Medicaid data to meet DMA needs.

3. Dissemination of Medicaid reports and data to other state agencies and the public as requested by DMA.

4. Training and support of users of ArcView in DMA and technical assistance for DMA staff in statistical analyses.

The State Center is statutorily charged to monitor the health status and health problems/needs of North Carolinians and the impact of services/programs that influence their health and well-being. Staffed with statisticians, epidemiologists, medical geographers, computer programmers/analysts, and having access to an array of health-related data sets, the State Center provides efficient and effective ways for Medicaid to obtain the most up-to-date analyses and information about the health of Medicaid clients and the quality of service provision to them. It has a long history of providing high quality services to all parties and offers continuity of analyses and information at an affordable cost.

The State Center will submit monthly invoices to DMA to claim costs in three categories:

1. The first category is to pay for a proportionate share of salary, fringe, and administrative costs based on time spent on the following:

   a) annually producing specified data reports for DMA Baby Love including the Medicaid birth outcome statistics, costs of low birthweight babies, and Medicaid births by age and county;

   b) providing technical consultation and support in order to monitor and/or evaluate health-related Medicaid program initiatives such as BABY LOVE, Medicaid Managed Care, and the Medicaid LTC project;

   c) responding to special one-time requests from DMA on projects or activities of interest to them;

   d) completing tasks defined in the annual work plan established between DMA and the State Center; and

   e) providing training and support of DMA users of ArcView.

2. The second category is the actual or prorated cost to store, process, and print the Medicaid data or reports as follows:

   a) annually producing the composite linked birth, Medicaid, WIC, HSIS file, and in the future, laboratory files for the purpose of evaluating service delivery costs and outcomes for Medicaid versus other clients;

   b) ITS charges to produce and/or analyze the Medicaid files and all linked files with Medicaid information used to meet the categories of reports specified above; and

   c) The paper/tape costs to run or distribute the reports specified above,

3. The third category is the cost of salary, fringe, and administrative costs to provide a full-time statistician to support the needs of the DMA Managed Care Unit Quality Management (QM) efforts.

   Administrative match will be provided by DMA for a Statistician II position to be responsible for data projects related to improving the delivery of health care services to Medicaid recipients in North Carolina. The position will be primarily responsible for analyzing data from all Medicaid Managed Care programs for the Pediatric Asthma Focused Care Study and other studies such as Well Child and Prenatal' Care. The position will assist in identifying study populations through claims and encounter data and will be responsible for gathering and analyzing HEDIS-like data for the Carolina ACCESS, ACCESS II/III and HMO Risk Contract programs from the MMIS and DRIVE. The position will analyze, interpret and report findings to the QM team for the development of quality

improvement/disease management strategies based on the statistical analysis of all data presented. Quality management is a continuous process, therefore, projects and studies will occur simultaneously.

DMA will provide the State Center the agreed upon number of user slots in the Medicaid DRIVE data warehouse/query system. The State Center will provide 1) the user hardware, **2)** the non-DRIVE software required to operate the system, and **3)** the LAN/WAN connection to access DRIVE through DMA. The State Center will assure adherence to the user agreements related to DRIVE.

The State Center will adhere to the State and Federal laws and regulations regarding confidentiality of Medicaid data. Information will not be released that could be used to identify individual patients and their health care without the expressed, written consent of DMA. The Medicaid provider numbers will not be contained on any material released by the State Center without the expressed, written consent of DMA. Also, refer to Section M and Section P of the overall DMA/DEHNR agreement dated 9/11/92.

DMA will receive a copy of all reports prepared by the State Center using Medicaid data.

Documentation to support the billings to DMA must be in strict compliance with federal requirements and is the sole responsibility of the State Center. Any audit exceptions or disallowances based on this agreement Will be the responsibility of the State Center. ***Also,*** refer to the "Guidelines for Requesting Federal Financial Participation for Medicaid Administrative Activities of the overall DMA/DEHNR agreement dated 9/11/92.

At the signing of this current MOU between the State Center and DMA, the MOU effective June 1, 1999 is considered null and void. The effective date of this agreement between the State Center and DMA is March 1,2000. This agreement shall remain in effect for five **(5)** years, at w **will** be re-executed.

J.
Director,
State Center for Health S

3-1-2000
Date

Paul K.
Director,
Division of Medical Assistance

3-14-2000
Date

Expiration Date: March 2005